
The Kulia Program: Psychiatric Rehabilitation in Hawaii

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Abstract

The Kulia Program was a culturally oriented, psychiatric rehabilitation program. It was developed in the only in-patient psychiatric hospital serving the 2 million multi-ethnic residents of the island state of Hawaii. From 1992-1999 the Kulia program was implemented on the only open, 36-bed unit of the Hawaii State Hospital with the mission of facilitating the reintegration of the chronically mentally ill into the community by encouraged its patients "to strive for the highest." Of the 238 patients discharged between 1992 and 1999 only 7% were re-hospitalized. Comparisons with other four treatment units during this period were not appropriate because of the difference in patient populations. These units provided long-term institutionalization of the criminally mentally ill, the behaviorally disoriented, mentally retarded and/or traumatically brain injured, and the behaviorally disoriented demented elderly. Their lengths of stay varied from 8 years to over 20 years in the hospital during this time period.

Introduction

Psychiatric rehabilitation began with Lamb.¹ He characterized moral treatment as the first organized psychiatric rehabilitation in the United States. The work of Adolf Meyer² emphasized the need to understand the role of social environment and biological factors in determining psychopathology and supported Clifford Beers³ in establishing the mental hygiene movement. The goals of the mental hygiene movement of the 1900s included rehabilitation.

The discovery and use of antipsychotic medication in 1950 increased the number of psychiatric patients able to live in the community, and with the federal funding of community mental health centers in the 1960s, a precipitous decline in the number of patients in psychiatric hospitals occurred. The work of Anthony,⁴ Anthony et al.,⁵ Liberman et al.,⁶⁻⁸ Wing and Morris,⁹ and Lamb and Lamb et al.^{1,10-11} helped to define the field of psychiatric rehabilitation.

In reviewing the historical development of psychiatric rehabilitation Anthony and Liberman¹² noted the importance of the 1943 amendments to the United States Rehabilitation Act that extended financial support and vocational rehabilitation services to the psychiatrically disabled. This legitimized the idea of training and rehabilitation of psychiatrically disabled individuals and grounded psychiatric rehabilitation in vocational rehabilitation.¹²

Anthony, Kennard, O'Brien, and Forbess¹³ defined the "mission"

of psychiatric rehabilitation as "to ensure that the person with the psychiatric disability can perform those physical, emotional, and intellectual skills needed to live, learn, and work in his or her own particular community, given the least amount of intervention necessary from agents of the helping professions." Most recently, Bachrach¹⁴ defined the central goal of psychiatric rehabilitation as enabling patients with long-term mental illness to develop their capacities to the fullest extent possible.

In the 1960s-1980s period the field of psychiatric rehabilitation grew and developed. In contrast to prior treatment approaches, psychiatric rehabilitation emphasized the evaluation of observable outcomes and the utilization of the evaluation.¹⁵ The outcomes being measured included: 1) client behavioral change (mastery of skills and activities) and 2) client and society benefits because of the psychiatric rehabilitation intervention. These authors provided critiques of existing measurement instruments.

Anthony et al.¹³ emphasized 25 myths that needed to be eliminated to prevent them from hindering the development of psychiatric rehabilitation. These included the beliefs that: increasing treatment compliance could singularly effect rehabilitation outcome; community based treatment setting were well utilized by persons who were psychiatrically disabled, where a person was treated was more important than how the person was treated, and a person's rehabilitative outcome was a function of the credentials of the mental health professional with whom the person interacted.

Anthony, Cohen, and Farkas¹⁵ specified the ten essential ingredients of a psychiatric rehabilitation treatment program that differentiated this program from program that were "rehabilitation" in name only (Table 1, *see next page*). These authors acknowledged the synonymous use of the terms psychosocial rehabilitation and psychiatric rehabilitation. Programs functioning as psychiatric rehabilitation programs "were designed to remove or reduce those residual handicaps which interfere with psychiatrically disabled person's abilities to function in their own communities." Anthony and Liberman¹² noted that multiple types of skills were required to implement patient-specific treatment plans targeted to maximize the strengths, to develop the skills, to decrease problematic behaviors, and to teach the behaviors needed by the patient to function in the patient's discharge environment.

The initial failure of mental health professionals to address the psychosocial needs and rehabilitation of the chronically mentally ill resulted in non-professionals and patients establishing psychosocial self-help clubs, such as Fountain House.^{16,17} The focus of Fountain House was: 1) to develop strategies to help people cope with the environment rather than succumb to it, 2) to achieve health induction rather than symptoms reduction, and 3) to foster a belief in the potential productivity of the most severely, psychiatrically disabled

Table 1.— Essential Ingredients of a Rehabilitation Program

(A* = Present in the Kulia Program)

1. Functional Assessment in Relation to Environment Demands (identification of the patient's strengths and deficits in relation to skill demands in the particular environment in which the patient plans to function)*
2. Patient Involvement in the Assessment and Intervention Phase Rehabilitation (patient communications his or her plans, experiences, feelings, ideas, and goals)*
3. Systematic Individual Client Rehabilitation Plans (sequential behaviors to be completed by the patient in order to achieve the rehabilitation goal)*
4. *Direct Teaching of Skills to Clients (developing a plan of what is to be taught and how it will be taught to the patient)**
5. *Environmental Assessment and Modification (environmental modification involving assessment of the strengths and deficits of resources in particular client environments and the development of programs to address each)**
6. Follow-Up of Clients in the Real-Life Environment (monitoring the patient's progress in his or her real-life environment maybe done through the report of significant others)*
7. Rehabilitation Team Approach (team approach enables all learning, living, and working skills needed to achieve rehabilitation/return to the community to be comprehensively assessed)*
8. Rehabilitation Referrals (psychiatric rehabilitation referrals are made as goal directed, not activity oriented, for a specific patient behavioral outcomes related to a specific functional deficit with a timeline for achieving the results)*
9. Evaluation of Observable Outcome and Utilization of Evaluation Results (accomplished by follow-up of clients in their real-life environments provides a foundation for the evaluation of accomplishments of practitioner and agency)*
10. Consumer Involvement in Policy and Planning (involvement of consumers, i.e. patients, in planning meetings and satisfaction ratings) * (Begun in 1998)

Modified from Anthony WA, Cohen M, Farkas M. A psychiatric treatment program: can I recognize one if I see one? Community Mental Health Journal 1982;18:83-96.

patients.¹⁶ Peterson¹⁷ spoke movingly of a change in his self-perception from "chronic patient" to "member" of the Fountain House community. He stressed the importance of an accepting, supportive environment in maximizing change and underscoring the importance of enabling each member to have his or her own apartment and to have meaningful activity in the person's life.

Background

In contrast to many mainland states, Hawaii is comprised of seven habitable islands. There is no majority population. Thirty-four percent of the Hawaiian population is Asian [Japanese (20%), Chinese (3%), Filipino (10%), Korean (1%)], 21% are Native Hawaiian or part Hawaiian, 22% are Caucasian, 21% are Other Mixed Ancestry (not including part-Hawaiian), and 2% are Other [African American (1%), Samoan/Tongan (0.8%), Puerto Rican (0.1%)].¹⁸ The ethnic composition of the Hawaii State Hospital Staff is reflective of the state and that fact facilitates an understanding of the cultural expectations and mores of Hawaiian, Filipino, South Pacific Islanders (Samoan and Tongan), Japanese, Caucasian, Chinese, African American, and Korean patients.

The Hawaii State Hospital (HSH), built in 1944 to provide psychiatric services to Hawaii residents, has had a checkered history. Overcrowding, excessive length of stay (years), and minimal quality of life standards for patients resulted in a federal consent decree in 1989 that mandated specific changes in patient-staff ratios, resources available to patients (food, clothing, personal space), type of treatment provided, and mandated the development of out-patient services for the least restrictive alternatives of care. The establishment of an affiliation with the Department of Psychiatry of the John A. Burns School of Medicine in 1991 brought medical school

faculty to the HSH, as clinical psychiatrists, to improve the assessment, care, and treatment provided to the patient population. The collaboration between the Adult Division of Mental Health of the Department of Health of the State of Hawaii and the Department of Psychiatry of the John A. Burns School of Medicine resulted in the HSH obtaining accreditation by the Joint Commission of Hospitals in 1996 and, again, in 1999.

The patient population was initially referred mainly from the acute emergency rooms of the islands of Oahu, Maui, and Hawaii as well as patients from the Department of Correction facilities on those islands that required in-patient psychiatric treatment. In 1991 in order to facilitate improved patient flow and to target treatment to specific patient populations, the HSH was reorganized into an acute admission unit, a transitional step-down unit, and five treatment units which focused upon specific populations: the elderly, the mentally retarded and persons with traumatic brain injury, patients with personality disorders who committed "high profile" crimes of murder and/or sexual assault, and chronically, mentally ill (one locked and one open unit). In several mainland states (e.g. New York state) each of these HSH units would be a separate state hospital housing a specific population, e.g., a hospital for the institutionalized mentally retarded, a forensic hospital for the criminally insane, and a hospital caring for the chronically, mentally ill with an acute admission unit.

This paper describes the development of the Kulia Program on the 36-bed, open treatment unit of the HSH. Focusing upon the chronically mentally ill; this psychosocial program was developed within a single unit of a state hospital to address the needs of its changing patient population.

Kulia Program

The Kulia I Ka Nu'u Program's name in Hawaiian means, "striving for the highest." Patients admitted to this unit were more likely to have a diagnosis of schizophrenia (75% of patients) and to have arrived at the hospital as being Unfit to Proceed from their court hearing because of mental illness, because of revocation of a Conditional Release, or because of misdemeanor charges caused by psychotic behavior. A small subsection of the patients were sexual offenders who had sexually assaulted or repeatedly exposed their genitalia. These patients were moved to the unit with the closing of beds in an older section of the HSH in 1992 and were believed to be able to participate in the Kulia Program and ready to move toward discharge from the hospital. Patients earned Patient Incentive Points (PIP) by maintaining a minimal level of personal hygiene and grooming, keeping their personal space organized with beds made, and participation in a scheduled program of activities as determined by the patient and staff observations reviewed in the patient's treatment team meetings.

Specific one hour educational, skills training, and interpersonal skills groups were held Monday through Friday from 9:30-10:30 followed by a 30-minute break before lunch (11:00-11:30) and from 13:30-13:30 following a 60-minute break. Patients had unscheduled time between 15:30-17:30. Patient could go to the gym for exercise, go for a community walk, read or watch educational television program or video on the units, or use the time for personal grooming. Patients who were unable to successfully utilize "free time" met with the patient's treatment team and target goals were

established. Some patients were placed in leisure time skills building module implemented by the Recreational Therapy Department to aid them in the development of leisure time interests. Dinner occurred daily from 17:30-18:00. Evening activities focused upon social, recreational activities such as word games, table tennis, pool, reading, and crafts. Alcoholics Anonymous (AA) meetings (twice per week) and Narcotics Anonymous (NA) meetings (twice a week) were part of the evening Kulia Program for those patients requiring substance abuse treatment.

The cultural basis of the Kulia Program was reflected in the incorporation of Hawaiian culture into every component of the program. The educational program including Hawaiian language and customs. Recreational activities included games indigenous to the islands (balancing a specially rounded stone). Crafts activities included making flower necklaces (leis). Fund raising activities featured Hawaiian foods including poi (pounded taro), a local delicacy - Spam musubi (a slice of fried Spam wrapped in rice circled by dried sea weed), and Portuguese malasadas (fried donuts). Patients from other cultures were encouraged to share their language, stories of creation, special foods, and societal organization in a class focused on the various cultures comprising Hawaii. Patients were encouraged to identify their unique history in a group focused on development through the life cycle. Recreational trips to important historical sites in Hawaiian culture and history on the island of Oahu were planned and implemented by the patient community. The Hawaiian Cultural Heritage component of the Kulia program, also,

included a bi-weekly group, called Malama Na Ike I and II. One group focused upon beautification of the grounds around the open unit with Native Hawaiian plants and an understanding of their significance in Hawaiian culture. The second group focused upon the history, culture, and language of the Hawaiian people. Patients from other cultural groups (African American, Caucasian, Japanese) participated in both groups depending upon their interest in these areas. Only on the open unit was this cultural focus incorporated throughout the treatment program. The presence of the HSH multicultural staff facilitated patient engagement and effective communication with the patient's treatment team.

Individual treatment sessions were held with members of the treatment team from 9:00-9:30 and 13:30-16:30 for 30 minutes to 60 minutes depending upon the focus of the session. Group psychotherapy sessions occurred in the afternoon time period, also. Table 2 summarizes one schedule of groups (educational, social skills, substance abuse treatment and prevention, prevocational and vocational rehabilitation, and community reintegration for one patient during one nine-week cycle of the Kulia Program. In the eighth week of each cycle, a treatment plan meeting was held. Patients and members of the patient's treatment team developed the individual schedule for the next 9-week cycle.

Patients had the opportunity to have input into the programming and the development of specific activities, such as fund-raisers. The monies raised were used for a specific patient community activity determined by the patients such as a cookout or trip to a location of

Table 2.— Kulia Schedule

KULIA SCHEDULE				
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8-8:30 Patient Rounds		Patient Rounds	Patient Rounds	
8:30-9:00 Community Meeting	Community Meeting	Community Meeting	Community Meeting	Community Meeting
9-9:20 Nursing Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session
9:20-9:30 Patients' Break	Patients' Break	Patients' Break	Patients' Break	Patients' Break
9:30 Substance Abuse Education Group (SW, Nursing - Activity room) Talk Story Group (Psychology - E Conf. Room) Substance Abuse Process Group "B" (SW, Nursing - Classroom 2) Living Skills (Ward OT, Nursing - Classroom 1) What's News? (Nursing - Lobby or Day room)	*8:30-10:30 Sex Offenders' Group (Psychology - Guensberg) Spiritual Journey (Psychology, Chaplain) Coping Skills (Ward OT, Nursing - Classroom 1) Library World (Nursing - Village Green Library) *10:30-11:15 Neuropsych Training Neuropsychology - Building L	Anger Management (Social Work, Nursing - Classrm 2) Beautification Activity (Nursing - Day area, courtyard grounds around E) Communication Skills (Nursing, Ward OT) Discharge Readiness I (SW, Nursing - Activity Room)	Computer Skills (OT Skills Center) *9-10a / *9-11a Basic Conversational Skills Grp (Nsg, MD - Activity Room) Feelings Through Music Group (RMT, Psychology - Auditorium) Remotivation Group (Ward OT, Nsg - Classroom 1) Stress-Ease II Group (RT, Nursing - Classroom 2) Relapse Prevention (Psychology, Dr. Wood, Dr. Zdzrow Guensberg Bldg) *10-11a / *11a-12p	Job Skills (OT - Skills Center) *8-9a *9:30-10:30a Skills Exploration (OT-Skills Ctr) *8-9a *8:30-10a Malama Na Ike Activity (Nsg - Community Cultural Sites & E) Kulia Brain Gym Group (Nursing - Activity Room) Crafts 'n Arts Group (RT, Nursing - Classroom 2)
10:30 TPs/Individual Contacts	TPs/Individual Contacts	TPs/Individual Contacts	TPs/Individual Contacts	TPs/Individual Contacts
11-11:30 Patients' Lunch	Patients' Lunch	Patients' Lunch	Patients' Lunch	Patients' Lunch
11:30-12:30 Patients' Rest Time	Patients' Rest Time	Patients' Rest Time	Patients' Rest Time	Patients' Rest Time
12:30 WORK Health Education Group (Nursing - Activity Room) Treatment Planning Group (Psychology, Nsg - E Conference Rm) Money Management (Ward OT, Nursing - Classroom 1) *1:30-2:30 Adult Education (DOE - Village Green Library)	*11:45-1:30 Escorted AA Community Meeting (RT, Nsg - Aikahi Church Site) WORK Gym with Unit E Staff (Nursing - Gymnasium) Personal Effectiveness (Ward OT, Nsg - Classroom 1) Symptom Management (Nursing, MD - Activity Room)	WORK Pass Prep Group (Nursing, Ward O.T. - Classroom 1) Medication Management (Nursing, MD - Activity room) Wellness Group (Nursing - Classroom 2) *1:15-7:00p: Community Reintegration Bus Module (RT - Community Sites)	WORK Substance Abuse Process Group "A" - (SW,Nsg-Classroom 2) Men's Activity (Nursing - Activity Room) Getting Along Group (RT, Nursing - Day room) Hygiene/ADL s/Etiquette Group (Nursing, Ward OT- Classroom 1)	WORK Polynesian Story-telling Activity (Nursing - E Conference Room) Cognitive Games (Nursing - Activity Room) Self-Esteem / Awareness (O.T., Nursing - Classroom 1)
1:30-2:00 Team Wrap-Up Meetings	Team Wrap-Up Meetings	Team Wrap-Up Meetings	Team Wrap-Up Meetings	Team Wrap-Up Meetings
2:00-2:30 Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session
2:30-3:15 Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session Model Making Group (R.T. - Day area) Percussion Group (RMT - Auditorium)	Educational Video (Nursing - Dayroom) Open Gym Activities (Gymnasium) Individual Session	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session Music Session (RMT - Auditorium)
7/6/98 - 9/4/98 CYCLE				

Hawaiian historical significance or to a specific cultural festival (Hawaiian Taro Festival, Japanese Bon Dance, Greek Cultural Festival, Native American Pow-Wow). Staff worked with the elected patient leaders to plan these activities.

A diabetic, Hawaiian-Chinese patient admitted with a diagnosis of Schizophrenia Paranoid Type and Crystal Methamphetamine Dependence, and Cannabis Abuse may be assigned to the following groups for her first 9 weeks on the unit: Understanding Mental Illness Group, Medication Education Group, Substance Abuse Education Group, Personal Effectiveness Group, Hawaiian Culture Group, Anger Management Group, Personal Grooming Group, an Adult Development Group, and a Spiritual Journey Group. These groups would enable the patient to improve her understanding of her mental illness, the role of medication in its treatment, the effect of substance abuse upon her mental illness, facilitate an identification of her bi-cultural heritage, improve her interpersonal interactions and ability to manage anger as well as personal grooming, and to aid the patient to compare her current life course with the usual tasks, goals, and relationship of persons of her age. The Spiritual Journey Group focused upon the role of religious belief in each person's life and encouraged the patient to identify it in her life. Recreational activities focused upon the development of alternative activities for remaining physically fit and identified specific patterns of leisure time activities, frequently a deficit for these chronically mentally ill. A special Recreational Therapy module helped patients to use public transportation with a structured program which established a destination, planned the buses to be taken, made the trip accompanied by a recreational therapist, and reviewed the extent to which each patient had met his or her goals in travel, behavior, and resource utilization. When indicated, neuropsychological and nutritional consultation were requested to address the specific goals of improving the patient's information processing and to improve diet planning and food choice for the diabetic patient.

The Patient Incentive Points (PIPs) that were earned could be used in the community reintegration activities on weekends that included traveling by van to participate in a local beach cleanup, attendance at a cultural festival (e.g. Hawaiian Taro Festival, Japanese Bon Dance, celebration of the Chinese New Year), visiting the local library to obtain a library card and to take out books and videos. PIP points were also used to go Wiki Wiki (fast and cheap) shopping to pick up items that were not provided by the hospital including special foods (siamen noodle soup), batteries for Walkman radios, and personal clothing. Wiki Wiki shopping provided an opportunity to emphasize the skills of budgeting and managing finances. These community reintegration outings served as an on-going monitor of patient's ability to manage their finances and to plan leisure time activities.

As patients improved in their level of appropriate behavior, each patient and patient's treatment team could elect to complete a vocational assessment during the in-patient hospitalization. Upon completion of the assessment, the patient working with the occupational therapist, identified work assignments within the HSH for which the patient could earn monies while demonstrating work readiness skills.

All group assignments for the Kulia Program resulted from the initial comprehensive evaluation of each patients involved in assessment by psychiatry, psychology, social work, nursing, recreational

therapy, and occupational therapy. Each patient's individual strengths and weaknesses were established in an interview with the patient's team's social worker. In treatment planning sessions the patient's goals for the hospitalization were identified and in monthly treatment planning meetings the attainment of these treatment goals was assessed and new goals established with the patient. The Kulia Program group assignments were for a 9-week cycle. In the eighth week of the current cycle the patient met with his or her treatment team and reviewed the patient's progress and established the patient's groups for the next cycle.

Outcomes

The HSH in the 1990s continued as a unique institution. Its various in-patient units housed very different patient population. Because 50% of its population came as forensic admissions, the average length of stay was over 18 months, including an additional 3-6 months to complete the court-ordered evaluation for conditional release and the receipt of the final judicial determination at the court hearing. In contrast to many mainland, public, in-patient units with length of stays in days or weeks, patients admitted to HSH's only open unit remained in in-patient treatment an average of nine months. Prior to the most recent reorganization of the hospital and an emphasis upon discharge, the annual discharge rate of the Kulia Program was higher than the discharge rate for the other units. The geriatric unit discharged patients only at death, an average of one per 2.5 years. The unit focused upon the treatment of high profile, personality disordered, criminals rarely discharged patients from the hospital resulting in Length of Stays of 6 years to over 20 years. Discharges to the community from the unit treating the developmentally disabled and traumatic brain injured patients, and the closed unit for the chronically mentally ill were difficult because of the limited number of community services and housing existing during this period and the impact of a narrow range of linked community mental health services existent at that time.

Because of the diverse mission of each unit based upon each unit's specific population, a comparison of the treatment programs and resulting readmission rates is an unequal comparison. Given this caveat, of the 238 patients discharged from the Kulia Program between 1992-1999, only 7% were readmitted. The readmission rate was approximately 20% for those few patients who were discharged from the four other treatment units. The lower recidivism rate for the open unit's Kulia Program was one important outcome marker in terms of in-patient costs saved as well as an indicator of the successful modification of the patient's problem behaviors that resulted in the need for in-patient treatment. This is a result similar to a naturalistic study of treatment of the chronically mentally ill that compared the states of Maine (usual treatment) and Vermont (variant of psychiatric rehabilitation program) with Vermont patients doing better in rates of rehospitalization, absence of symptoms, employment, living successfully in the community, and global functioning.¹⁹

The presence on the grounds of the HSH of a halfway house, privately run, facilitated a physical transfer from the in-patient Kulia Program to outpatient treatment. The proximity of this residence to the former inpatient unit was important for some very fragile patients with chronic mental illness who had significant problems with the transition from the in-patient setting. Although formally

discharged from the hospital, these patients could remain on hospital grounds while making their first initial transition into community care.

Comment

The Kulia Program provides one successful model of incorporating cultural diversity within an in-patient psychiatric rehabilitation program in a state hospital serving a diverse patient population. Although designed originally primarily for chronically, mentally ill, schizophrenic patients, the program evolved to include work with patients with dual diagnoses involving substance abuse as well as patients with psychosexual disorders and offenses. The maintenance of these patients in their discharge communities is a reflection of the success of the program. The importance of the linkages that the Kulia Program established with community services and outpatient treatment teams was recognized and incorporated into a new treatment model currently being implemented at the HSH to facilitate discharges and to decrease the Length of Stay for the total hospital population. Linkages that did not exist effectively before the development of the Kulia mode are being established and institutionalized by the Adult Division of Mental Health of the Department of Health of the State of Hawaii as a new comprehensive network of psychiatric community services are developed. In contrast to most mainland states only in 1999 was an Oahu island-based Assertive Community Team (ACT) established through the initiative of the Adult Division of Mental Health of the Department of Health of the State of Hawaii in its effort to develop a comprehensive range and network of services.

In order to meet the mandates of the Department of Justice to standardize care across all treatment units at the HSH, the Kulia Program model was incorporated into a standardized rehabilitation model developed by the Adult Division of Mental Health of the Department of Health of the State of Hawaii. In order to facilitate the standardization of treatment, the HSH has had a decrease in its bed capacity and its units have been reorganized, again, into one admission and three treatment units. All treatment units now are locked and contain a mixed population of patients: the chronically mentally ill; the dually diagnosed; and the personality disordered, substance abusing, court-committed criminal offenders. Intensive staff training²⁰ preceded the unit reorganizations and continues as a new, standardized treatment model incorporates a schedule of educational, skills training, anger management, and interpersonal skills groups centrally held on the campus of the HSH.

In the HSH structure of the 1990s the Kulia Program provided an example of what could be accomplished with psychosocial rehabilitation in an increasingly diverse population. Its emphasis upon Hawaiian culture facilitated the sense of history, prior accomplishments, and sense of heritage for Hawaiian and part-Hawaiian patients as well as the diverse culture comprising the state of Hawaii. Although serving a segment of the HSH patient population very well, the majority of HSH patients at that time could not participate in the Kulia Program.

As with any change, there are losses and gains. Although the Kulia Program no longer exists, the model of rotating classes addressing activities of daily living, social functioning, education about medication and treatment, and community reintegration activities comprise the core of classes now centrally offered to all patients on the

revised treatment units. Efforts to establish a Fountain House model on the island of Oahu have begun.

Conclusion

The Kulia Program developed on the only open unit of the only public mental health hospital in the state of Hawaii met the 10 essential features of a psychiatric rehabilitation program as articulated by Anthony, Cohen, and Farkas in 1982 (see Table 1). It was unique in providing a psychiatric rehabilitation program that incorporated a culturally sensitive component. In order to standardize care to a redefined and downsized forensic patient population at the HSH the Kulia Program formally ended in 2000 with the reorganization of the HSH into a closed, forensic facility.

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